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REPORT OF CONSULTANT VISIT
TO

Glenwood Resource Center

November 17 To 19, 2008

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Description of Tour Activities

From November 17-19, 2008, this consultant, in conjunction with the United States Department of Justice, completed a tour of Glenwood Resource Center in Glenwood, Iowa. I reviewed the records of 10 individuals who died in 2008 prior to my visit. I also conducted a number of staff interviews, and participated in a number of meetings.

I met with the Medical Director, the Director of Nursing, and attended meetings, specifically the AM Medical/Administrative meeting. These meetings are conducted daily at 8:00 am with all physicians and administrators, such as the director of nursing and selected other department heads participating. The intent of these meetings is to improve communication within the medical department and other departments most likely to be affected by medical conditions and decisions. Although this is a fairly recent change, it appears that these meetings may well improve the quality of health care in the facility.

I also attended the Interdisciplinary QI data review on Wednesday, November 15. There is a range of new quality improvement activities in the facility which are reviewed weekly to see if they are yielding appropriate information, and if policy and procedure need to be changed.

I also looked at a number of documents including:

- The records reviewed of individuals who had died in 2008 prior to my visit:

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There were six deaths in 2007, eleven in 2006, and three in 2005. While I am not sure I have the complete data for 2004, there were 5 deaths from 4/11/04 to 8/12/04.

I reviewed all the records of deaths listed above for 2008, with the exception of , who died at the age of . GRC has an aging population, and a certain number of deaths will occur each year. Examination of the following deaths focused on the systems that worked and where care exceptions contributed to the terminal event. I found only one of ten cases where this was true.

Interviews

Director of Nursing

I interviewed Connie Brown, the current Director of Nursing on Monday afternoon. She reviewed the current staffing and status of nursing recruitment. There are 70 nurses on staff. The position known as Health Care Coordinator is an 8-4:30 position and there is one such position assigned to each home. These nurses are responsible for the development and implementation of the health care portion of the individual service plans.

Nursing has recently become a centralized service. All nurses are located in Lacy Hall as of August, instead of being directly tied to a team. We discussed extensively the issue of protocols and competency, with my biggest concern being the issue of increased expectations of nurses in the area of physical assessment. Only in the last 12-15 years have nurses been expected to be competent to do physical assessment of the abdomen and chest. Nurses graduating prior to the mid-80's may or may not have these skills, and all nurses need to demonstrate their competence periodically, since the majority of residents with developmental disabilities are not able to communicate directly their signs and symptoms. As a result, changes in behavior such as PICA, aggression, SIB, hands in mouth, or increase in agitation and sleeplessness have all been traced to medical antecedents, particularly constipation, bowel obstruction or GERD. When the nurse has only marginal assessment skills, these conditions can often be missed.

Ms. Brown reported that a Skills Fair will be held shortly and a Mosby on- line program which has 800 clinical procedures with a formal skill demonstration mechanism that will be used by the facility to both update and confirm nursing competence in these areas. There are currently 6 vacancies (a little more than 8%), and Ms. Brown does not believe that this is a major issue since there is not a lot of competition for nurses in the immediate area and salary is competitive and benefits are more than adequate. There are also 11 new positions in nursing which have yet to be filled: 2 nursing coordinator positions, 8 LPN positions, 1 Wound/Clinical Care position, and an Infection Control RN position.

Direct care staff (called CM aides) gives all non-parenteral medications with nurses doing the remainder. Although I think Ms. Brown would prefer LPN's to do this job, I have no issue with well-trained staff doing the oral medications, since they tend to do this with a very limited number of people whom they know very well. That decision should be based on the capacity of the facility to assure that the outcomes of safe administration and monitoring of response is assured and that people are adequately trained to do the job. The infirmary is in House #469 and has 12 beds. Residents are generally returned from the hospital to this unit, and may be admitted from another unit by physician's orders. There are two full-time nurses on the Physical/Nutritional Management Team (PNMT). There is coverage by nurses on this team 7 days a week.

In December a fairly rigorous peer review process was to have been initiated. Review of records from the last few months satisfied me that full body assessments by nurses are documented at critical times, such as before transfers, upon return to the facility, at the time

of any critical signs and symptoms. For the most part, I found these assessments to be consistently completed on the documentation that I reviewed for the past 2-3 months. This documentation was less reliable prior to that.

I was pleased with Ms. Brown's interview for a number of reasons. First, it is clear to me that there is now strong leadership in this department. Secondly, I believe that the Quality Improvement measures that are now being put in place should show some real improvements in the practice of nursing at GRC within a reasonable period of time. However, most of these changes are very new or yet to begin. Therefore, I cited only partial compliance on some of these, due to the need for them to have sufficient time to mature and prove their effectiveness.

Medical Director

I met with Dr. Mohammed Rehman, the current medical director on Monday afternoon of the week of our tour. He is an internist by trade. He carries a small case load in addition to his medical director position. There are three more primary care positions, two psychiatrists in addition to two psychiatrists who come on a consulting basis. Dr. Khan is a neurologist who is full time on staff. In addition there are a number of outpatient clinics held on grounds, including surgery, EENT, optometry, gynecology and podiatry. There is a dental surgeon on staff. Dr. Rehman is currently negotiating with another physician to fill a staff vacancy. This physician was not on board at the time of our tour.

There is a medical administrative meeting daily with the physicians, psychology, nursing, and a PMN team representative. There are five physicians who share call from 8am to 8 am and from 8 am on Saturday to 8 am on Monday.

Dr. Rehman is new in the Medical Director position. From February to May of 2008, he was the Acting Director. Another medical director was hired in May, but left the position in June. Dr. Rehman has actually been in a position to implement policy, procedure, and QI since the middle of the year.

Dr. Rehman agreed that the two biggest challenges in the population remain the management of aspiration and bowel obstruction. There are now many QI factors being implemented. Since most of these processes are relatively new, I gave partial compliance to most of them because, like nursing, they need time to mature. I was however, very impressed and hopeful about the comprehensiveness of the systems described to me. We will simply have to wait and see how well they work in terms of improving and maintaining the quality of care being provided.

I believe that Dr. Rehman is a very competent administrator and I am impressed with the systems that he is currently implementing. He is very new in this position and the majority of the policies and procedures that he is implementing are less than six months old. For this reason, I did give only partial compliance for this round, but anticipate that the department will be in full compliance on the next round.

Recommendations:

1. Always consider negative changes in behavior as having the possibility of a medical antecedent. PICA is associated with GERD and reflux esophagitis about 30% of the time. Hands in mouth and agitation are also likely to be an indicator of gut pain.

2. In individuals with a diagnoses of GERD, particularly if there is evidence of a hiatal hernia and chronic esophagitis, the probability of aspiration of stomach contents on a chronic basis is very high. Elevating the head of the bed in individuals with neuromotor disabilities is often ineffective, since it is not the head of the bed that is refluxing. Positioning the person such that the head and trunk are elevated in alignment is the burning issue and may require special adaptations to achieve. A lot of persons who are ambulatory have poor sitting posture and may need to be supported to sit such that they are sitting on their ischeal tuberosities with their ears over their shoulders.

3. Management of constipation needs to be much more aggressive and include the use of dietary management measures, such as increasing fiber, fluids and probiotics, and not just relying on laxatives that create dependent bowels. Severe constipation, megacolon and abdominal distension were noted as incidental findings in a number of the deaths and may actually have contributed to the terminal event. These are, however, problems that developed initially decades ago. Bowel assessments are inconsistent with one another in a number of instances. That is, the nurse reports one thing, and the physician another within a short time of one another.

4. Nurses should have good assessment skills and these should be confirmed periodically, perhaps every other year. Many older nurses (e.g. more than 25 years since graduations) were not trained in physical assessment skills expected of more current graduates. They may have not had the opportunity to learn and practice these physical assessment basics so their assessments may not be reliable. For instance, lack of bowel sounds in all four quadrants is not the only sign of a bowel obstruction. High tinkling, hyperactive bowel sounds above the belly button are often the sign of a small bowel obstruction. What bothered me was that in at least two cases of the deaths, there were signs of fecal regurgitation either before or after the death. This means that the precipitating factor was probably a bowel obstruction preceding the terminal event.

5. Documentation and follow-up of data needs to be monitored routinely as part of the QI system, since it is a very high maintenance activity and will not sustain without

frequent review and correction. Documentation is not a naturally reinforcing activity and falls off quickly without feedback. Data should be relevant and people need to know that it is functional or it will not be done accurately or with enthusiasm.

6. Review of GRC Nursing Care Policy and Procedures indicate that while there is policy requiring notification of the physician promptly in the event of significant change in physical condition, it may be a bit vague with regard to actual situation and timelines in which the nurse should take action to begin emergency procedures. Health care policies might be made more specific with regard to "panic value" changes in vital signs. Most good nurses know these well, but in the case of JT, initiation of emergency care was delayed at least 4 hours, although I do not believe it would have made a difference in the outcome.

7. There needs to be a way to document the time of the event in health care notes that makes it clear when the events being described actually occurred. Currently the time that the note is written is what appears to be recorded, and it is at the discretion of the writer whether or not to record the time of the event that they are describing.

8. I am not enthusiastic about one annual, four quarterlies and 12 monthly reviews by nurses, which is the current requirement for every resident. One of the outcomes of establishing health care levels for residents is that you can restrict the intense oversight (with accompanying documentation frequency) to those who really need it. I know you have many high risk individuals, but remember you can obstruct the forest with too many trees (that is, too much documentation). As the system develops, start asking if the process is worth the effort.

9. I would recommend that GRC obtain the services of a Gastroenterology consultant as I believe that the incidence of GERD, chronic esophagitis, and hiatal hernia in this population is much higher than you know at the moment. In one Illinois facility when a consulting gastroenterologist was hired, within a year, they determined that in cases where dysphagia was diagnosed, the cause of silent aspiration was GERD about 80% of the time.

10. In a Louisiana facility, a consulting gastroenterologist was able to reduce the frequency of constipation by 90% over a 3 year period by a number of measures, with nutritional measures and increasing fluids the primary measures to do so. Another facility reduced suppository use by 50% simply by providing a glass of water to each resident between breakfast and lunch and lunch and dinner. I would be happy to provide you with some contacts to learn more about this if you choose.

11. GRC needs some help with the quality of pre and post positioning for intake and emptying. The quality of positions for people at mealtimes has a profound impact on gastric emptying, and is an issue for those who move little or poorly, and can be very troublesome for those whose posture leaves much to be desired. Moreover, systems for monitoring quality of positions (Physical Management) need to be implemented at all staff levels, rather than hung on the PNM staff, who simply can't present at every meal. These lungs are assaulted for the most part a mini-trickle at a time, and many of your residents do not have the oral motor sensitivity to protect their airways from micro-aspiration.

12. Keppra has been noted to have increasing rage as a side effect. I am not sure that this has been noted in the drug literature, but it is suspicious in the case of . It was not, however, a direct causative factor in death.